GraniteCare

Health and Human Services Elder Affairs Committee
GraniteCare Sub-Committee
January 26, 2005

Agenda

- Objective
- A review of Medicaid: background and context
- A review of the problem and challenges
- A review of the impacts
- How has DHHS responded
- A review of outstanding requests for data
- Outline process and next steps
- Questions

Objectives

- Outline the need for Medicaid reform
- Outline the DHHS organization
- Outline on next steps

Medicaid Program

Background and Context

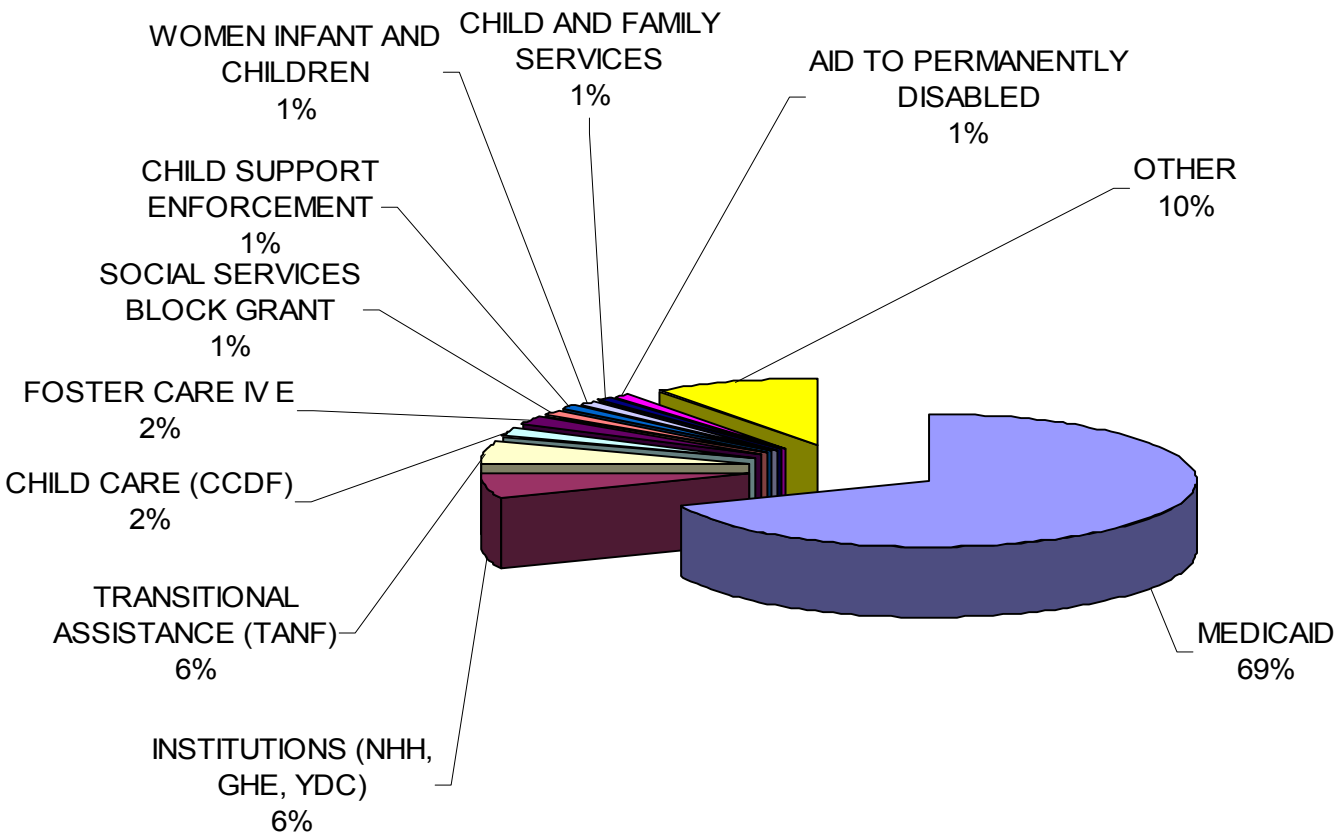
- RSA 126-A:4 There shall be a Department …. "organized to provide a comprehensive and coordinated system of health and human services" … to promote health.

- Medicaid is central to this mandate.

Medicaid Program

- **Source of Health Coverage:** Provides coverage for approximately 64,000 families and 97,000 individuals in December of 2004.
- **Designed to support those in need.** Safety net function for children and the elderly. Relative importance as a source of coverage varies significantly across the state.
- **Community providers are the link to clients.** 4,000 providers receive reimbursement from the Department for the Medicaid services they provide to NH citizens.
- **Federal Partnership.** Federal government pays for $.50 of every $1 spent on Medicaid services.

Medicaid in DHHS

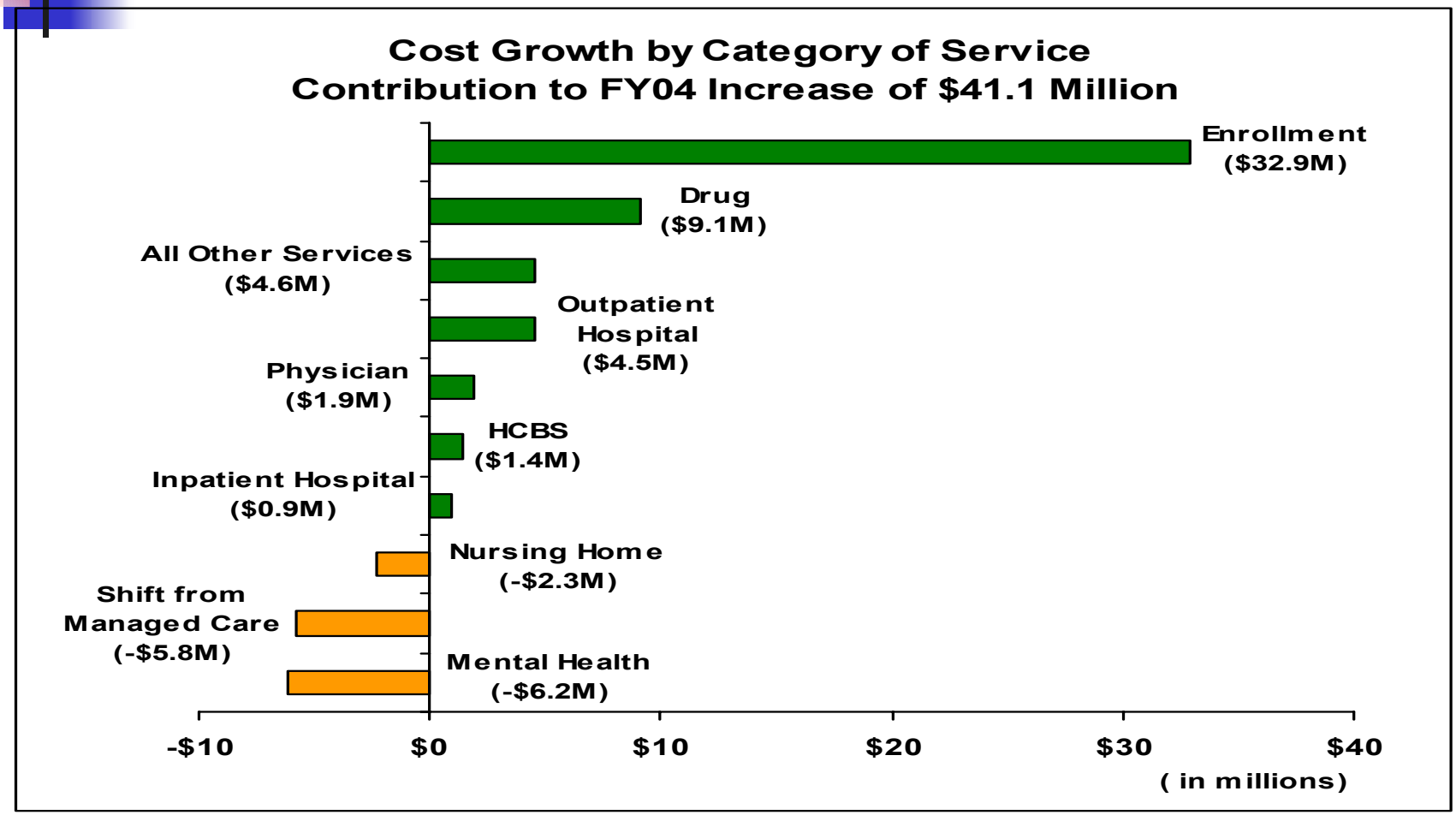


SFY '03

Medicaid Cost Drivers

- Drivers
  - Enrollment
  - Price and medical cost inflation
  - Utilization
- Underlying Factors
  - Economic conditions
  - Aging Population (increasing demand for services)
  - New Drugs, Technologies
- Specific Categories of Service with Most Growth
  - Pharmacy, Outpatient Hospital Services, Providers

Impact of Cost Drivers



Who's Eligible?

	Percent of Federal Poverty Guidelines			
Family Size	100%	185%	250%	300%
1	$9,310	$17,224	$23,275	$27,930
2	$12,490	$23,107	$31,225	$37,470
3	$15,670	$28,990	$39,175	$47,010
4	$18,850	$34,873	$47,125	$56,550
5	$22,030	$40,756	$55,075	$66,090

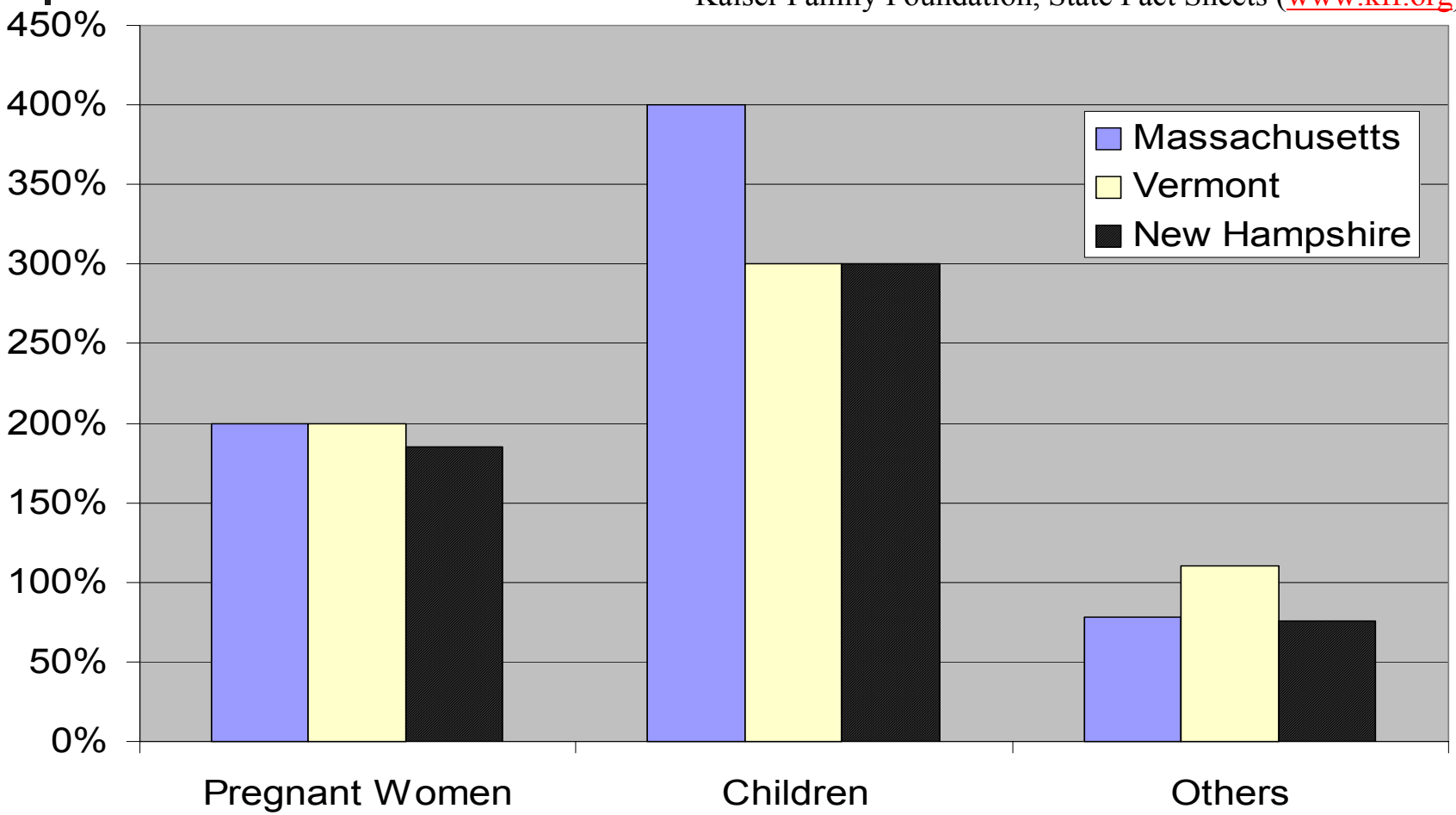
Federal Poverty Guidelines

Who's Eligible?

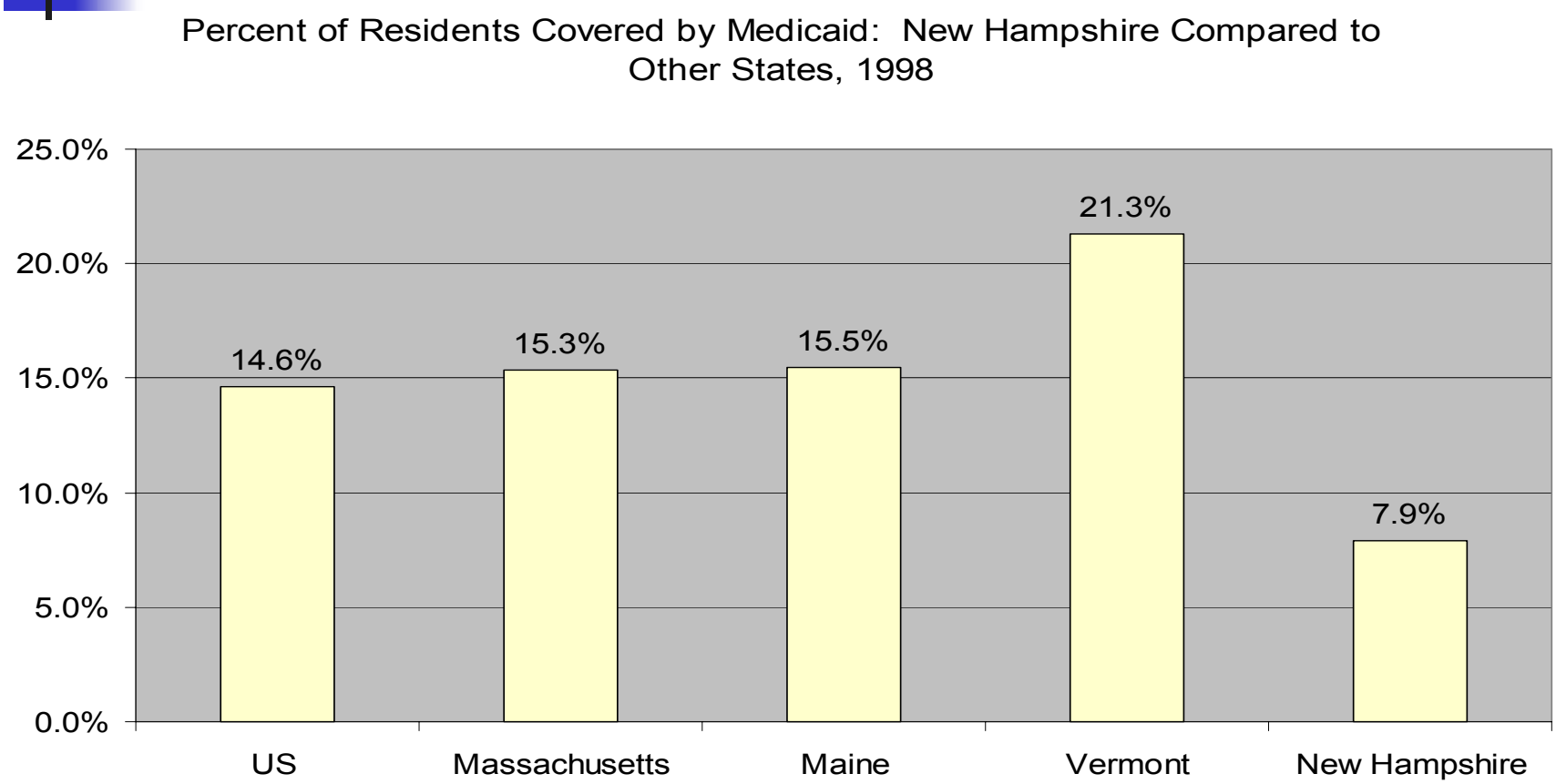
- Lower income adult with children and the elderly (~79% of the federal poverty level)
- Disabled adults
  - Includes both physically and mentally disabled adults and those with traumatic brain injury.
- Pregnant Women (185% of the federal poverty level)
  - Single pregnant woman with incomes up to $17,224 are eligible.
- Children (300% of the federal poverty level)
  - A child living in a home with a single parent and income up to $37,470 would be eligible.
  - Includes foster children

Medicaid Eligibility Levels for Pregnant Women, Children and Others

Kaiser Family Foundation, State Fact Sheets (www.kff.org)

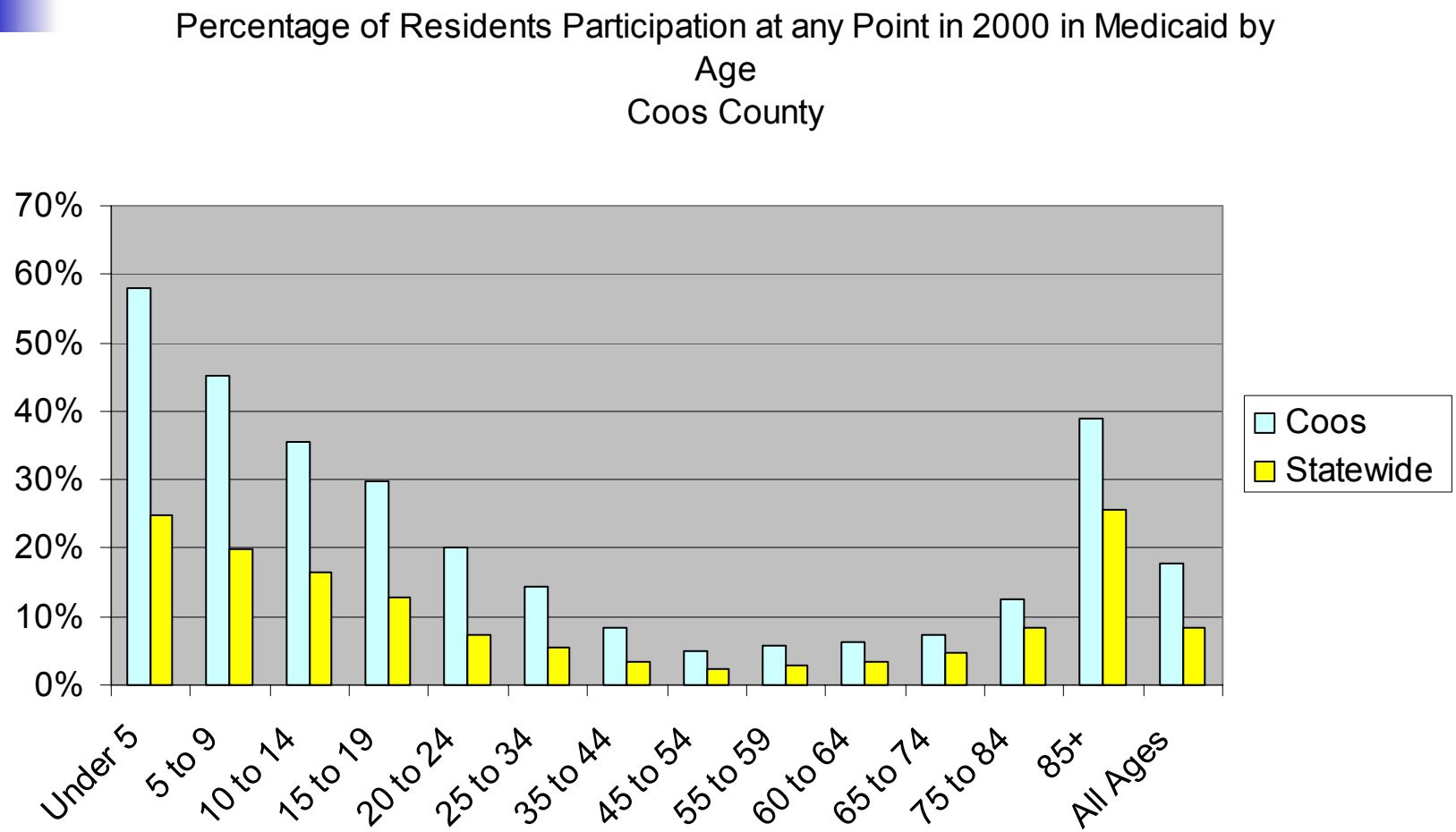


Share of Population Covered



ORA analysis of Kaiser Family Foundation data on enrollment and residents, State Fact Sheets, www.kff.org

People and The Safety Net Function: Provides Extensive Coverage in Economically Challenged Areas.



Source: ORA Analysis of Medicaid Claims Data and 2000 Census Data

Benefit Mandates: Federal & State

Federal Mandates
Intermediate Care Facility Nursing Home
Outpatient Hospital, General
Inpatient Hospital, General
Physicians Services
Rural Health Clinic
Home Health Services
Skilled Nursing Facility Nursing Home
Dental Service
SNF Nursing Home Atypical Care
ICF Nursing Home Atypical Care
Laboratory (Pathology)
I/P Hospital Swing Beds, SNF
Family Planning Services
I/P Hospital Swing Beds, ICF
Advanced Registered Nurse Practitioner
X-Ray Services
State Mandates
Home & Community Based Care, Developmentally Impaired
Clinic Services (School Services)
Home & Community Based Care, Elderly & Chronically Ill
Personal Care

Benefits: Optional Services

Optional Services	
Dispense Prescribed Drugs	Optometric Services Eyeglasses
Mental Health Center	Ambulance Service
Private Non-Medical Institutional For Children	Adult Medical Day Care
Health Maintenance Organization (HMO)	Crisis Intervention
Furnished Medical Supplies Or Durable Medical Equipment	Physical Therapy
Private Duty Nursing	Clinic Services (w/o School Services)
Day Habilitation Center	Medical Services Clinic
Psychology	Intensive Home And Community Services
Wheelchair Van	Podiatrist Services
Placement Services	Occupational Therapy
ICF Services For The Mentally Retarded	Chiropractic
Inpatient Psychatric Facility Services Under Age 22	Speech Therapy
Home Based Therapy	Audiology Services
Child Health Support Service	Outpatient Hospital, Mental

Medicaid Administration

- Nursing home and home and community based care services for the elderly → Bureau of Elderly and Adult Services
- Community Mental Health Services → Bureau of Behavioral Health Services
- Acute Care Services (Rx, Hospital, Physician) → Office of Medicaid Business and Policy.
- Home and community based care services for the developmentally disabled → Bureau of Developmental Services.
- Care for those with traumatic brain injuries → Bureau of Developmental Services.

Medicaid Medical Expenditures

Office of Medicaid Business and Policy	$297,908,320
Bureau of Elderly and Adult Services	$253,437,272
Bureau of Behavioral Health Services	$ 73,279,725
Bureau of Developmental Services	$135,197,111
Division for Children, Youth and Families	$ 26,122,083

Critical Medicaid Issues

- Budget
- GraniteCare
- Medicare Part D – Medicare Pharmacy Benefit
- Pharmacy Benefit Management
- Medicaid Enhanced Care Management (Disease Management)
- Developmental Services Waiting List
- Reimbursement levels for providers
- Purchasing a new Medicaid claims system

The Problem

Medicaid Challenges

Problems in the Current System

- System imbalances
  - Nursing home and home and community based care
  - Acute care and prevention
  - New Hampshire Hospital and Community Mental Health
- Service delivery systems
  - Multiple silo based systems each with a point of entry
    - Focused on the provider, not the consumer
  - No systemic review in 25 years
  - Duplicate administrative structures
  - Multiple case management systems
  - Systems narrowly "optimized"
- Antiquated information technology systems

Financial Impacts

- System is not sustainable financially
  - Medicaid has passed education as largest budget item
- Projections for current system with no change
  - Today $880M will grow to over $2B by 2015
- Rates of reimbursement
  - Threaten participation and viability of provider networks
  - Service access
  - Litigation
- Cost drivers
  - Traditional cost drivers plus
  - Inappropriate service utilization by recipients

Consumer Impacts

- Lack of primary care physician/medical home
- Lack of knowledge of or incentive for appropriate and cost effective care options
- No incentive for appropriate prevention
- Confusion in navigating the system
- Lack of consistent outcomes focus leading to greater independence and service cost management

System Impacts

- Antiquated and non-integrated information systems technology
  - Cumbersome data exchange and analysis
  - Time consuming and expensive billing and reimbursement systems leading to duplication of effort and delays in reimbursement
  - Not able to leverage commercially off the shelf technology
  - Lack of benchmarks and appropriate "report cards" on performance of providers
- Lack of timely, comprehensive and accurate service resource information

DHHS Action

Reorganization

Medicaid Modernization

Cost Containment

DHHS Actions

- Beginning in the 2nd Quarter of State Fiscal Year 2004, DHHS
  - Established an "efficiency and restructuring" team to assess the organization design and identify key areas for improvement
    - An organization to embrace not just adapt to change
  - Analysis highlighted key areas requiring change
    - Medicaid Modernization
  - Immediately address mandated General Fund reductions
    - Required for both SFY '04 and '05
    - Plan and achieve "back of budget" projections
    - No or minimal impacts on service to recipients

DHHS Reorganization

- DHHS initiated a comprehensive review of its organization beginning in October 2003
  - Phase 1 Analysis
    - Identified key problem areas to address in a restructure
  - Phase 2 Realign and restructure
    - Outlined high level structure and concept in January 2004
  - Phase 3 Service delivery system integration
    - Integrated effort into Medicaid modernization

Key Organization Changes

- Medicaid Business and Policy Office
  - Manage acute care benefits for Medicaid and coordinate policy across all Medicaid benefits
- Division of Community Based Care Services
  - Merged three divisions focused on the delivery of services in the community
    - Bureau of Developmental Services
    - Bureau of Behavioral Health
    - Bureau of Elderly and Adult Services
  - New Hampshire Hospital and Glencliff Home for the Elderly
- Division of Public Health Services
  - Merged public health with the Division of Alcohol and Drug Abuse Prevention and Recovery
    - Substance abuse pervasive and a public health problem

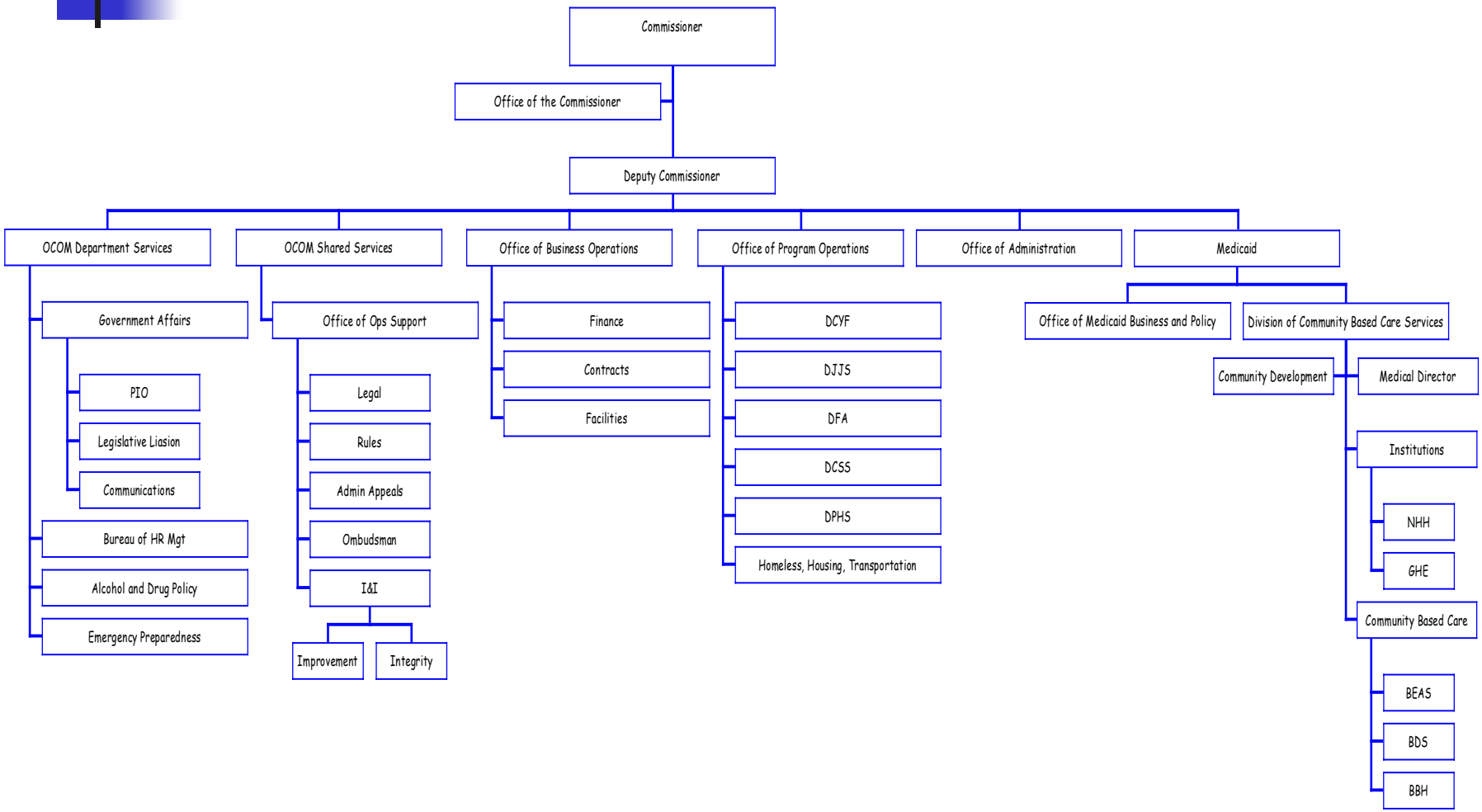
Key Organization Changes

- Establish a Bureau of Continuous Improvement and Integrity
  - Independent of any service delivery or program system
  - Consolidate fraud, recovery and third party liability
- Elevated critical cross divisional services
  - State Medical Director
  - Homeless, Housing and Transportation
  - Drug and Alcohol policy
- Streamline District Office service delivery system
  - Strengthen customer service and community outreach

Key Organization Changes

- Created several "shared services" support offices
- Ensures maximizing available resources
- Consistent process and procedure
- Best practices
- Services include
  - Human resources
  - Contracts processing
  - Legal and rules
  - Licensing
  - Finance
  - Facilities
- Evolving a "team" structure for key departmental challenges

Functional Organization



DHHS Action

Medicaid Modernization

Time is Now

- Clear focus on New Hampshire's challenges
  - Medicaid costs now greater than all other budget items, including education
- Additional national challenges loom
  - Bush administration commitment to contain Medicaid cost
- Unsustainable program over the long term
  - Be the leader in Medicaid program innovation

Consumer-Centered Principles

Policy Options

New Hampshire

- Medical Home
- Care Management
- Service System Integration
- Rebalance Systems
- Performance Based Payment
- Community Care
- Incentives
- Prevention

Other States

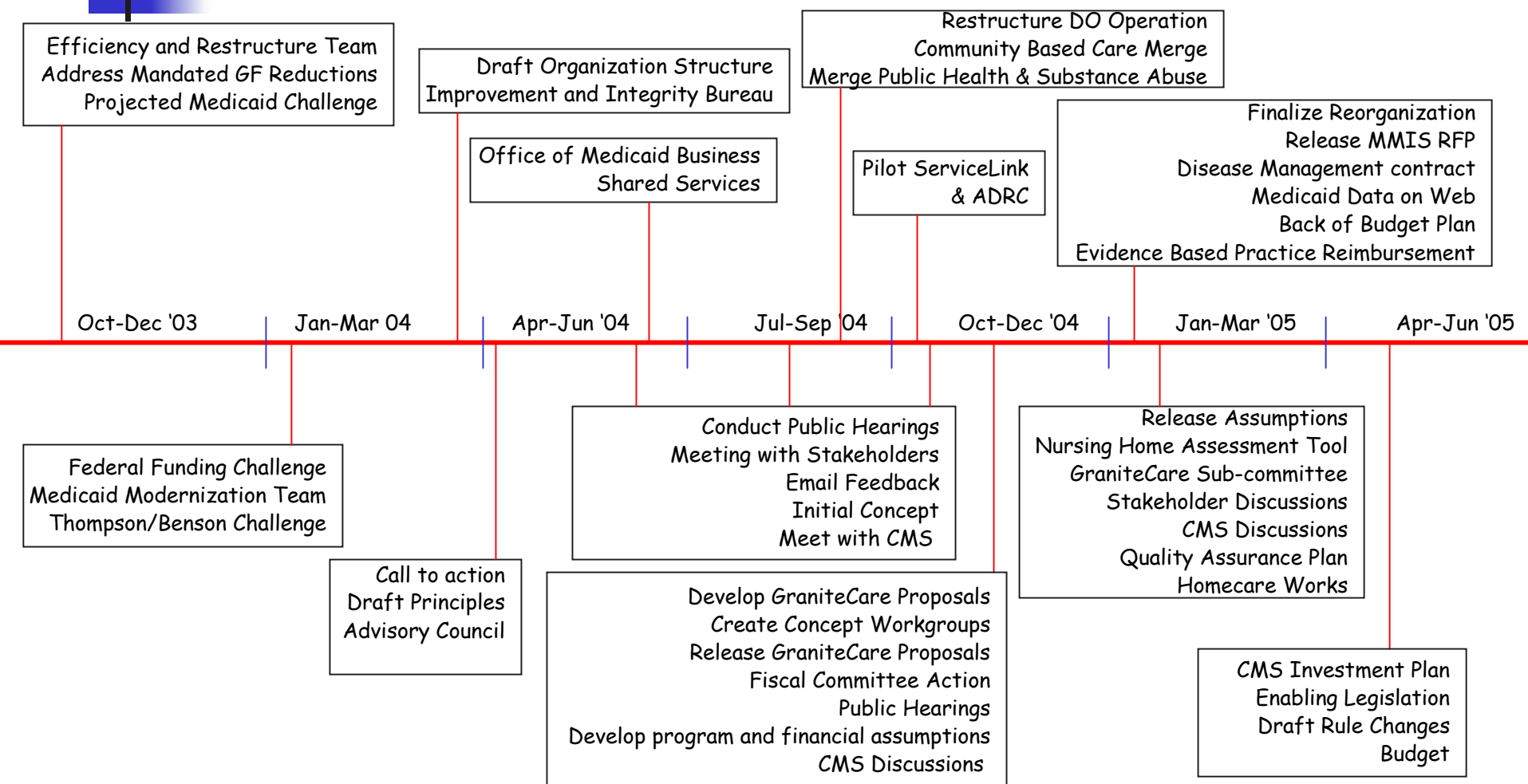
- Increase Taxes
- Premiums & Co-pays
- Service Reductions
- Eligibility Reductions
- Rate Reductions

GraniteCare

- Aims to transform and rebalance the State's Medicaid program by
  - Enhance prevention efforts across all populations
    - Leading to better care and outcomes and
    - As a way to contain long term cost growth
  - Shift the primary focus of care from a provider-focused to a consumer-focused system
  - Streamline and integrate disparate service delivery systems
  - Using principles near and dear and to NH
    - Choice, community care, personal responsibility, quality to name a few

- Goal is to stimulate discussion and a search for answers with policy makers, the public and the key stakeholders.
  - Contain costs, improve service efficiencies and produce better outcomes

Time Line


Efficiency and Restructure Team
Address Mandated GF Reductions
Projected Medicaid Challenge
Draft Organization Structure
Improvement and Integrity Bureau
Office of Medicaid Business
Shared Services
Restructure DO Operation
Community Based Care Merge
Merge Public Health & Substance Abuse
Pilot ServiceLink
& ADRC
Finalize Reorganization
Release MMIS RFP
Disease Management contract
Medicaid Data on Web
Back of Budget Plan
Evidence Based Practice Reimbursement
Oct-Dec '03
Jan-Mar 04
Apr-Jun '04
Jul-Sep '04
Oct-Dec '04
Jan-Mar '05
Apr-Jun '05
Federal Funding Challenge
Medicaid Modernization Team
Thompson/Benson Challenge
Call to action
Draft Principles
Advisory Council
Conduct Public Hearings
Meeting with Stakeholders
Email Feedback
Initial Concept
Meet with CMS
Develop GraniteCare Proposals
Create Concept Workgroups
Release GraniteCare Proposals
Fiscal Committee Action
Public Hearings
Develop program and financial assumptions
CMS Discussions
Release Assumptions
Nursing Home Assessment Tool
GraniteCare Sub-committee
Stakeholder Discussions
CMS Discussions
Quality Assurance Plan
Homecare Works
CMS Investment Plan
Enabling Legislation
Draft Rule Changes
Budget

Next Steps

- There are several interdependent tracks we are following
  - Continued discussion and consultation with the Legislature including leadership, the LFC and the sub-committee chaired by Rep. MacKay
    - Participate in workgroups to assess policy and fiscal issues early on
  - Continued dialogue with stakeholder groups to both further develop and refine the concepts as well as work on key "building blocks"
    - Provider networks, legislators, Governor's office, others
  - Continued dialogue with the Centers for Medicare and Medicaid Services (CMS)
    - NH the 1st state to take Medicaid Modernization seriously and are working with CMS for guidance and for investments
  - Continued collaboration and discussion with Governor Lynch as we develop our budget for the next biennium

CMS* Discussions

- A "waiver" in simplest terms is a plan for Medicaid innovation by a State. Waivers require:
  - Public input
  - Demonstrate and evaluate the results of a new concept
  - Budget neutrality over a 5-year time frame
- Legislative Fiscal Committee voted on November 23, 2004 on a 9 to 1 margin that DHHS do the following:
  - Begin negotiations with CMS on waiver
  - Nothing is finalized until action by the Legislature
  - New Hampshire has met with Federal officials 5 times since that vote and is seeking:
    - Affirmation of key transformational concepts
    - Investment of resources to build and sustain the infrastructure
- CMS discussions help NH clarify its options
  - *Centers for Medicare and Medicaid Services

DHHS Action

Cost Containment

SFY '04 Budget Reductions

- Achieved over $11M in legislatively mandated reductions to the general fund
  - Key measures included
    - Footnote reduction/non-personnel $8.1M
    - Footnote reduction/personnel $1.9M
    - Hiring delay $1.4M
- Returned an **additional $39M** to general fund
  - Program adjustments
  - Personnel lapses
  - Contract savings
  - Additional Federal revenues
- Savings achieved without impacting service levels, eligibility, benefits or service quality.

SFY '05 Budget Reductions

- Achieved over $10M in legislatively mandated reductions to the general fund
  - Key measures included
    - Footnote reduction/non-personnel $8.4M
    - Footnote reduction/personnel $1.9M
    - Other footnote reductions $8.5M
- Targeting an **additional $70M** in general fund revenues and expenditures
  - Program adjustments
  - Personnel lapses
  - Contract savings
  - Additional Federal revenues
- Savings achieved without substantially impacting service levels, eligibility, benefits or service quality

Other Cost Containment

- Reduction in Service costs
  - Single case management billing for dual diagnosed clients with developmental disability and mental illness
  - Area Agency consolidation in North country
  - Low utilizer caps
  - Preferred Drug List

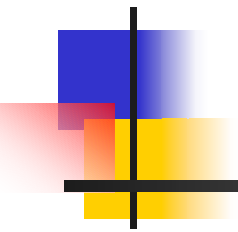
Data Request Status

- Review requests for information from previous meeting
  - Nursing home utilization, 10 year history
  - HCBC utilization, 10 year history
  - Agency maintenance request
  - Population statistics by age category
  - Cost comparison of DD system versus institutional care
  - Surveys of population re acuity

Key Documents

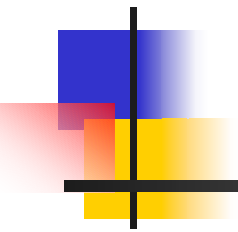
- GraniteCare, Recommendations to Modernize Medicaid on November 10, 2004
- GraniteCare, Financial Projections & Critical Assumptions on January 5, 2005.
  - Both available at www.DHHS.NH.Gov

- Medicaid Modernization, Background Information on May 4, 2004



Questions

Thank You



Appendix

Program Division Bureaus

Children and Families

- Division for Children, Youth and Families
  - Child protection
  - Child development
  - Family & community services
  - Quality improvement
  - Fiscal services
  - Policy and information services
- Division for Juvenile Justice Services
  - Residential services
  - Field operations
  - Administrative services

Financial Assistance

- Division of Family Assistance
  - New heights
  - Field operations
  - TANF and TANF Administration
  - Program operations
  - Finance and administration
- Division of Child Support Services
  - Finance and admin
  - NECSES
  - Policy planning and training
  - Field operations
  - Customer service

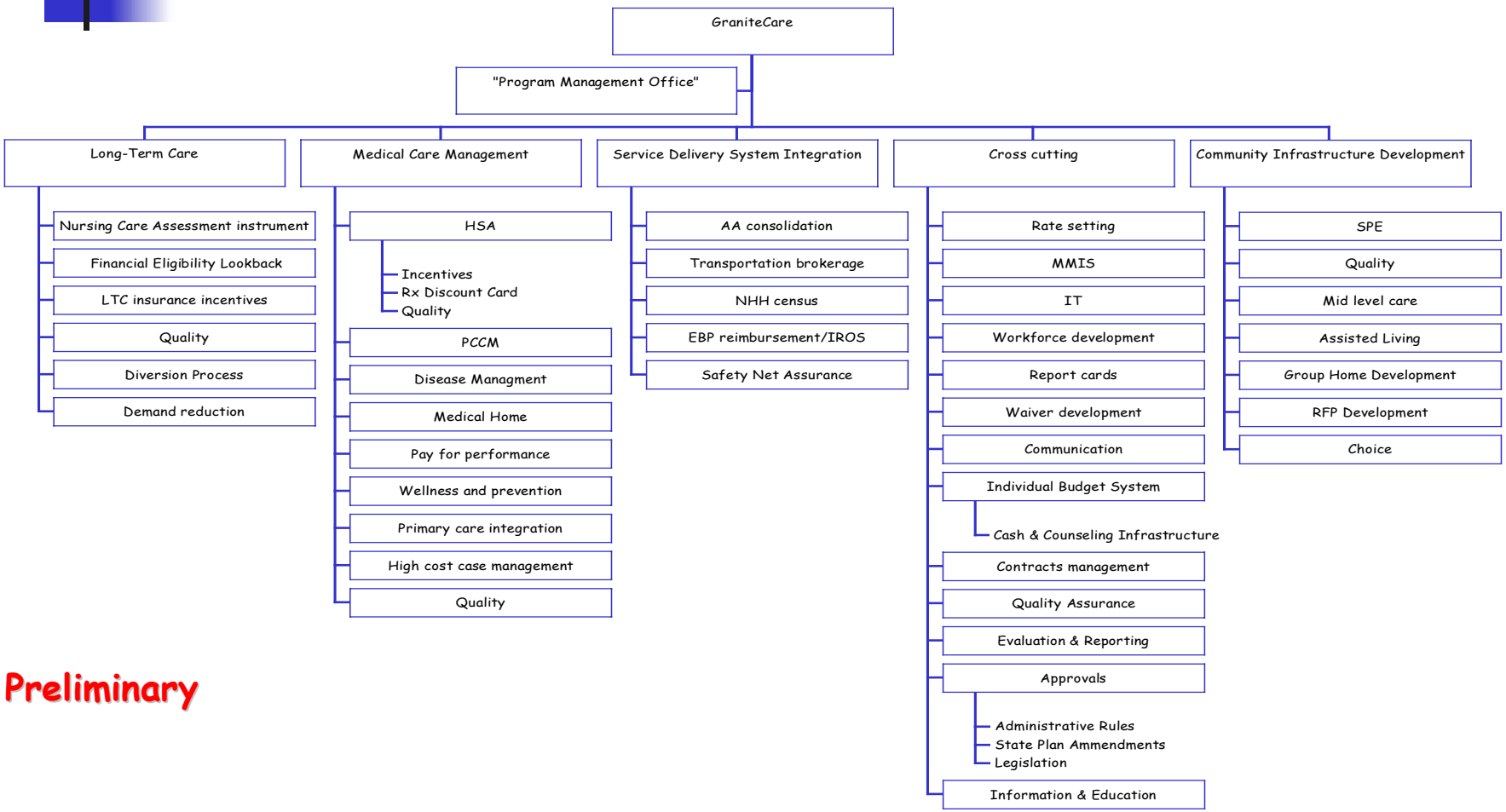
Public Health

- Division of Public Health Services
  - Laboratory sciences
  - Disease control
  - Community health services
  - Policy & performance management
  - Prevention

Medicaid Business

- Division of Community Based Care Services
  - Behavioral health
  - Developmental services
  - Elderly & adult services
  - New Hampshire hospital
  - Glencliff Home
- Office of Medicaid Business and Policy
  - Medicaid policy
  - Health care data and reporting
  - Health care research
  - Medical services
  - Dental director

GraniteCare
Major "Building Blocks"



Preliminary

Concept Development

- Established 7 cross functional teams to develop each of the major concepts
- Identified key external stakeholders and initiated discussions on detailing concepts
  - Single point of entry: meeting with several area agencies, independent case managers and counties
  - Health Services Accounts: meeting with medical groups
  - Pay for performance
  - HCBC Quality Assurance system

Rebalance Long-Term Care System

- Redirect consumers to less restrictive and less expensive levels of care
- Create community-based alternatives and infrastructure to care for consumers
- Reduce the need for care in institutional settings
- Reduce the reliance on public funds
  - Change the eligibility process extending the "look back" period

Single Point of Entry

- Primary functions within the single point of entry include
  - Diagnosis, assessment and treatment plans integrating all facets of the consumer's health
  - Individual budgets – based on medical/financial necessity and community/family supports
  - Comprehensive care management
  - Consumer self-directed care and choice in provider selection
  - Extensive information, referral and access to triage services
  - Medicaid report cards

Strengthen Care and Disease Management

- Shift the focus of the current system from one where care is largely not managed to a comprehensive and integrated care management approach.
- Core elements include
  - Contract with an organization for creation of a medical home
  - Coordination of various contracts for disease management and utilization management
  - Use of predictive modeling and individualized care plans
  - Provide patient-level data and provider-level data to populate Medicaid report cards
  - Education and training support to individuals enrolled in a Medicaid Health Services Account

Health Services Accounts

- Implement a first in the nation "health services account" for populations for whom the State provides services on an optional basis
  - Focused on populations with income >133% of FPL
- Core elements include:
  - A required prevention component
  - Optional services managed by the consumer
  - Major medical coverage for services beyond the budget
  - Incentive bonuses for
    - Achieving prevention goals
    - Spending less than budgeted amount

Key Activities

- Long-term care
  - Nursing home assessment instrument
  - Quality assurance system for HCBC
  - Review of rates
  - HomeCare works for workforce development
- Single Point of Entry
  - Pilot implementations integrating ServiceLink with ADRC
  - Discussions with AA, counties and independent case managers
  - Initial focus will be on developmental services and the elderly
  - Integration of mental health will be in a later phase with the current focus on strengthening primary care linkage

Key Activities

- Care Management Coordination
  - Disease management contract approved by CMS
  - Prevention and wellness guidelines
  - High cost case management
- Health Services Accounts
  - Discussion with various groups
- Other
  - MMIS reprocurement that will streamline the way in which we work with providers
  - Change the MIMS billing system to an Evidence Based Practice model